Pathways To smartcare

Wellness4Schools

VACCINE RESERVATION & CONSENT FORM FOR STUDENTS

School Site _South Fayette Township HS theatre lobby_ **Date of Clinic**: ___8/4/2020_____

Complete all Information: We will verify your insurance coverage & eligibility of vaccination/s requested

Please return form to your child's school nurse by July 13th. 2020. Online registration closes that day as well.

PATIENT AND INSURANCE/PAYMENT INFORMATION

STUDENT NAME _____ **AGE** _____ **DATE OF BIRTH** _____ **(M)** ___ **(F)** ___

ADDRESS _____ **APT** _____

CITY _____ **STATE** _____ **ZIP** _____

PHONE (1) _____ (2) _____ **LAST 4 DIGITS of SOCIAL SECURITY NUMBER**_____

MOTHER'S NAME _____ **FATHER'S NAME** _____

OR **GUARDIAN'S NAME** _____ **RELATIONSHIP** _____

INSURANCE COMPANY'S FULL NAME_____

ID # _____ **GROUP #** _____

GUARANTOR FOR STUDENT _____ **RELATIONSHIP TO STUDENT** _____

ADDRESS IF DIFFERENT THAN ABOVE _____

GUARANTOR PHONE _____ **GUARANTOR BIRTHDATE** _____

PARENT/GUARDIAN CONSENT: As the legal parent/guardian I give permission for my child to receive the following vaccine(s): (PLEASE CHECK)

Energix-B: _____ Hepatitis B (ages 0-19, 3 doses 0, 1, 6 mo)

GARDASIL 9: _____ HPV (Human Papillomavirus) (ages 9-26, 2 doses 0, 6-12mo)

MMR II: _____ Measles, Mumps, Rubella (ages 12 mo+, 2 doses)

MENVEO: _____ Meningococcal "A,C,W,Y" Disease (ages 10-25)

BEXSERO: _____ Meningococcal "B" Disease (ages 10-25, 2 doses at least 1 month apart)

IPOL: _____ Polio (ages 2 mo- 6yrs, 4 doses – 4th dose given between 4-6yrs)

DTaP: _____ Diphtheria, Tetanus, Pertussis/Whooping Cough (younger than 7 years of age)

TDAP: _____ Tetanus, Diphtheria, Pertussis/Whooping Cough (ages10+)

VARIVAX: _____ Varicella (Chicken Pox) (ages 12 mo-12yr, 2 doses 3 mo. apart) (ages 13+, 2 doses 4 weeks apart)

Consent: I request and voluntarily consent that the above vaccine(s) be given to _____ of whom I am the parent or legal guardian, and I acknowledge that no guarantees have been made concerning the vaccine's success. I have been given the Centers for Disease Control and Prevention Vaccine Information Statements. I have read these documents and have no further questions at this time. I understand the risks and benefits of the vaccines. I understand the possible side effects and warnings and precautions that should be taken into consideration prior to administration of the vaccine. I understand that I may cancel this permission at a later date by contacting the school. Lastly, **I will complete the Patient Screening Questions on the back of this form.**

Privacy Practices: I acknowledge that Notice of Privacy Practices were made available to me.

Financial Responsibility: I have been notified that my insurance may deny payment entirely or partially for the vaccine or injection. If my insurance denies payment for the entire amount or for a partial amount, I agree to be personally and fully responsible.

Pathways Wellness Program, LLC bills under Hart Medical Consulting, Dr. Bryce Palchick & does not charge for an office visit

Signature of Parent or Legal Guardian: _____

Date: _____ **Printed name of above**: _____

Student Name: _____ **DOB:** _____

PATIENT SCREENING INFORMATION **PLEASE CIRCLE YES OR NO TO THE QUESTIONS BELOW:**

1. **Is your child allergic to eggs, egg proteins, Gentamycin, latex, gelatin or thimerosal?** **Yes** **No**
2. **Has your child ever had a serious reaction to any vaccine?** **Yes** **No**
3. **Has your child ever had Guillain-Barŕe syndrome?** **Yes** **No**
4. **Does your child have a seizure disorder?** **Yes** **No**
5. **Does your child have asthma, recurrent or active wheezing or taken medicine for asthma (including inhalers) in the past 12 months?** **Yes** **No**
6. **Is your child under 18 years of age currently receiving aspirin or aspirin containing therapy?** **Yes** **No**
7. **Is your child pregnant or nursing?** **Yes** **No**
8. **Does your child have any diseases (e.g., cancer, lupus, or human immunodeficiency virus [HIV] or acquired immunodeficiency syndrome [AIDS]) or take a medication (e.g., steroids or chemotherapy) that lowers the body's resistance to infection?** **Yes** **No**
9. **Has your child received a vaccine within the past 30 days?** **Yes** **No**
   If yes, please list name of vaccine(s): _____ **Date** _____
10. **Does your child have any of the following long-term health problems? (PLEASE CIRCLE)**
    heart disease lung disease kidney disease metabolic diseases (e.g., diabetes) other _____
11. **Please let us know if your child has close contact with anyone who has a weakened immune system and must be in a protective environment (eg, an individual who has had a bone marrow transplant).**
    Please describe: _____

NOTE FOR FLU VACCINE ONLY: If you answered YES to questions 1, 2, 3, or 4, your child should NOT receive an influenza vaccine through the school vaccination program. If you answered YES or left blank any of the questions 5 through 11, it is recommended that your child receive an injectable influenza vaccine.

Allergies or medical alert: _____

Signature of Parent or Legal Guardian: _____

Date: _____ **Printed name of above**: _____

********** **VACCINE(S) ADMINISTERED** **(To Be Completed By Vaccine Administrator)** **********

FLULAVAL _____ 90686		**Other Vaccine** _____ CPT:_____
Energix-B _____ 90744	**Menveo** _____ 90734	**BEXSERO** _____ 90620
GARDASIL 9 ____ 90651	**IPOL** _____ 90713	**DTaP** _____ 90700
MMR II _____ 90707	**VARIVAX** ____ 90716	**TDAP** _____ 90715

ADMINISTRATION CODE: **INJECTABLE** _____90471 **Each Additional Shot** _____ 90472

FOR CLINIC USE ONLY						
Vaccine	**Date of Service**	**Manufacturer**	**Lot #**	**Site/Route**	Dosage Vol	**VIS Date**
Flu Injectable				LD RD IM	0.5ml	8/15/2019
Energix-B				LD RD IM	0.5 ml	8/15/2019
Gardasil 9				LD RD IM	0.5ml	10/30/2019
MMR II				LD RD SC	0.5ml	8/15/2019
Menveo				LD RD IM	0.5ml	8/15/2019
Bexsero				LD RD IM	0.5 ml	8/15/2019
Ipol				LD RD IM	0.5 ml	10/30/2019
DTaP				LD RD IM	0.5ml	4/1/2020
Tdap				LD RD IM	0.5ml	4/1/2020
Varivax				LD RD SC	0.5ml	8/15/2019

Signature of Vaccine Administrator:_____ **Signature Date**:_____ (Rev 4/30/2020)